



ICMR Specimen Referral Form for COVID-19 (SARS-CoV2)

INTRODUCTION:

This form is for collection centres / labs to enter details of the samples being tested for Covid-19. It is mandatory to fill this form for each and every sample being tested. It is essential that the collection centres / labs exercise caution to ensure that correct information is captured in the form.

INSTRUCTIONS:

- Inform the local / district / state health authorities, especially surveillance officer for further guidance
- Seek guidance on requirements for the clinical specimen collection and transport from nodal officer
- This form may be filled in and shared with the IDSP and forwarded to a lab where testing is planned
- Fields marked with asterisk(*) are mandatory to be filled

SECTION A – PATIENT DETAILS

A.1 TEST INITIATION DETAILS

*Sample collected first time : Yes No

If No, Patient ID :

A.2 PERSONAL DETAILS

*Patient Name: **VIKRAM SINGH PANWAR**

Father's Name:

*Age: **39** Years

*Gender: Male Female Others

*Occupation: **Other**

*Mobile Number: **9599271279**

*Mobile Number belongs to: Self Family

*Nationality: **India**

*Present patient address: **E 383**

*Downloaded Aarogya Setu App: Yes No

GALI NO 7 WEST VINOD NAGAR

Pincode: **110092**

*District : **NEW DELHI**

*State : **DELHI**

(These fields to be filled for all patients including foreigners)

Aadhaar No. (For Indians):

* Passport No. (for Foreign Nationals):

A.3 SPECIMEN INFORMATION FROM REFERRING AGENCY

*Specimen type	Throat Swab <input checked="" type="checkbox"/>	Nasal Swab <input checked="" type="checkbox"/>	Bronchoalveolar lavage <input type="checkbox"/>	Endotracheal Aspirate <input type="checkbox"/>	Nasopharyngeal Swab <input type="checkbox"/>
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*Type of test **RT-PCR Rapid Antigen Test (RAT)**

*Collection date **29/01/2021**

*Sample ID(Label) **NDDIH9029012021**

If, RT-PCR test, name of lab where sample is sent for testing **APLLTNND - Aarogya Pathcare LLP, Tilak Nagar, New Delhi**

* Mode of Transport used to visit testing facility

Symptomatic Asymptomatic

Contact of a lab confirmed case : Yes No

Please Note - Hospital form is required for the patients visiting OPD, IPD and Emergency and Community form is required for patients under containment zone/ Non-containment area/ Point of entry/ Testing on demand

***A.3.1 For Community**

Not Applicable

A.3.2 For Hospital*Cat 4: Testing on Demand**

* Fields marked with asterisk are mandatory to be filled

Please Note: Section B1 and B2 need to be filled for both Community and Hospital settings.

Section B3 needs to be filled only for Hospital settings

Section B- MEDICAL INFORMATION**B.1 CLINICAL SYMPTOMS AND SIGNS**

Cough	<input type="checkbox"/>	Loss of taste	<input type="checkbox"/>
Sore throat	<input type="checkbox"/>	Diarrhoea	<input type="checkbox"/>
Fever	<input type="checkbox"/>	Breathlessness	<input type="checkbox"/>
Loss of smell	<input type="checkbox"/>	Other symptoms, please specify	<input type="checkbox"/>

Date of onset of First Symptom :

B.2 PRE-EXISTING MEDICAL CONDITIONS

Diabetes	<input type="checkbox"/>	Over weight/ Obesity	<input type="checkbox"/>
Heart disease	<input type="checkbox"/>	Hypertension	<input type="checkbox"/>
Chronic lung disease	<input type="checkbox"/>	Cancer	<input type="checkbox"/>
Chronic Kidney disease	<input type="checkbox"/>	Any other please specify	<input type="checkbox"/>

B.3 HOSPITALIZATION DETAILS

Hospitalized : Yes No

Hospital State:

Hospital District:

Hospital Name:

Hospitalization Date:

TEST RESULT (To be filled by Covid-19 testing lab facility)

Date of sample receipt (dd/mm/yy)	Sample accepted/Rejected	Date of testing (dd/mm/yy)	Test result (Positive/Negative)	Repeat Sample required (Yes/No)	Sign of the Authority(Lab in charge)